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Illinois Department of Public Aid

THE MEDICAL ASSISTANCE PROGRAM

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MEDICAL ASSISTANCE PROGRAM

The Medical Assistance program provides for payment of allowable medical care received by 1) public aid grant recipients, and 2) certain other individuals and families who do not need assistance to meet their general living costs but who do require help in meeting the cost of medical bills.

The program, financed jointly by the state of Illinois and the federal government, is administered by the Illinois Department of Public Aid through its local offices in the state's 102 counties.

WHERE TO APPLY

Persons receiving Aid to Families with Dependent Children (AFDC) are eligible for medical services; consequently they are not required to apply for Medical Assistance. Aged, blind, or disabled persons who are receiving state supplementation to federal Supplemental Security Income (SSI) payments are also eligible for Medical Assistance and are not required to apply.

Other individuals or families who need assistance to meet the cost of current medical care may make application for Medical Assistance at the public aid office in the county of residence. If need for Medical Assistance occurs while hospitalized, application for this assistance may be made while in the hospital. If the person asking for assistance is unable to complete the application, it may be made in behalf of the applicant by a relative or other person who has sufficient knowledge of the applicant's circumstances to furnish information.

INFORMATION TO APPLICANTS FOR MEDICAL ASSISTANCE

1) **How Soon Should You Find Out If Your Medical Assistance Application Was Approved? What Are the Time Limits?**
Within 45 days of the date you applied, unless you are applying on the basis of disability, in which case the decision must be made within 60 days.

2) **What If the Department Doesn't Decide If You Are Eligible For Medical Assistance Within These Time Limits?**
If the Department makes a decision on your application after these time limits, the Department may have to pay you back for bills you paid after the time limits because of the Department's delay. Save copies of any bills paid after these time limits. The Department will send you a letter if you are eligible for being paid back under this provision.

3) **What Do You Get If Your Application Is Approved?**
If your application is approved, the Department will pay bills for services it covers for all the time you are eligible. This can include up to three months prior to the month in which you apply and the time you are awaiting a decision after you apply. You should, if possible, **not** pay your medical bills until you learn if you are eligible for medical assistance so that the Department can pay them.

SERVICES AVAILABLE

Medical Services. The Medical Assistance program is designed to provide essential medical services required by the applicant's condition due to illness, infirmity, or disability when such medical care is recommended by a qualified practitioner, and when the necessary care is not available to the individual from any other source.

The medical services and supplies for which payment can be provided are: in-patient and out-patient hospital services; clinic care; physical rehabilitation services; laboratory and x-ray services; family planning services; nursing care in the home; skilled nursing facility care; home health care services; special duty nursing care for a hospital patient; care in intermediate care facilities; physicians' services in the office, patient's home, hospital, nursing home, or other appropriate place; psychiatric services; early and periodic screening for diagnosis and treatment of

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children (Medichek); dental care; eye care; podiatry services; chiropractic services; physical therapy, occupational therapy, speech therapy, and audiology provided by or supervised by a qualified therapist; drugs, medical supplies, sickroom needs, appliances and prosthetic devices; second opinions regarding the need for surgery.

Funeral and Burial Expenses. Funeral and burial expenses are allowable for otherwise self-supporting persons who are receiving services under the Medical Assistance program in accordance with the department's payment standards when 1) the deceased was eligible for medical services at the time of death, 2) the estate is insufficient to pay the cost of funeral and burial, and 3) no legally responsible relatives are able to pay the costs.

Food Stamps. Persons and families receiving Medical Assistance may also be eligible for food stamps. They should consult the local public aid office.

Social Services. Applicants and recipients of Medical Assistance are eligible for information, referral and follow-up services; for help with plans when alternate care arrangements are needed when leaving a state hospital; and for a range of social services provided by other state agencies.

ELIGIBILITY FOR MEDICAL ASSISTANCE

Persons who have sufficient income and assets to cover their general living expenses but who need assistance to pay their medical expenses will qualify for Medical Assistance if they meet all of the following eligibility requirements:

Financial Eligibility. Individuals or families may be eligible for Medical Assistance when the amount of their resources considered available to meet their medical needs will not meet the cost of allowable medical care. In

determining an applicant's or recipient's eligibility for Medical Assistance , resources considered available to meet medical needs are 1) non-exempt income available over a six-month period in excess of the department's standards, 2) non-exempt liquid assets exceeding the department's standards, 3) available contributions from responsible relatives, and 4) third party resources such as Medicare or health insurance.
Persons legally responsible for support of needy relatives are spouse for spouse and parents for the support of children under age 21; except that a parent is not responsible for a child age 18 or over if it can be determined that the child has in fact established a consistent pattern of independent living arrangement prior to the child's application for assistance.

Income. Income and other money resources available to the applicant or recipient will be considered for the six-month period for which the person's eligibility is being determined for medical assistance.
The established six-month period of eligibility determined for each applicant begins with the month when medical service is given, provided the applicant meets all eligibility requirements. Assistance may be granted up to, and including, three months prior to application if necessary.
In determining eligibility and the extent of need for Medical Assistance, the individual's or family's income is considered the non-exempt income available for the six-month period. A portion of income may be exempt from consideration in determining eligibility for Medical Assistance in accordance with income exemption policies. Six months non-exempt income in excess of the medical assistance standard is considered available for payment toward medical care costs.

Assets. Assets exempt from consideration in determining the eligibility of applicants for Medical Assistance are: homestead property, clothing and personal effects,

household furnishings, business or farming equipment essential to produce income, motor vehicle(s), certain group life insurance and other life insurance if the cash value does not exceed $1000 per eligible family member.
Also exempt are the cash value of non-homestead property, stocks, bonds, savings accounts, and cash, provided the total value of any or all the items does not exceed $1500 for one person, or $2250 for a client and spouse residing together, and $50 for each additional dependent family member. The value of assets exceeding these amounts is considered available to apply toward medical expenses.

Summary of Financial Eligibility. An applicant's or recipient's non-exempt income (including available contributions from responsible relatives) and non-exempt assets over an established six-month period are considered in the determination of financial eligibility for Medical Assistance. A person or family having non-exempt income and assets in excess of the income and assets standards noted above may still be eligible if medical care costs exceed the surplus resources available to them.

Residence. Applicants for the Medical Assistance program must be residents of Illinois and must be citizens of the U.S. or have a legal alien status. Temporary absence from the state does not disqualify an applicant if all other eligibility requirements are met.

Other Eligibility Factors. With the exception of the financial eligibility requirements, WIN and Job Service registration requirements, and school attendance requirements for persons over age 18, all other eligibility factors are the same as those in effect for AFDC. Families may be eligible for the Medical Assistance program if:

1) There are one or more children under the age of 21 in the family group;

2) The children are deprived of parental support or care by the death, physical or mental incapacity, full or partial unemployment or continued absence for such reasons as unmarried parenthood, divorce, separation, imprisonment, or military service of either parent; and
3) The children are living with an adult who is their parent or other close relative such as an adoptive father or mother, grandmother, grandfather, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle or aunt.

Pregnant women with no children may receive Medicaid if all other eligibility factors are met. A person without young children at home may be eligible for Medical Assistance, if the person is:

65 years of age or over; or blind to the extent that even with glasses he is unable to perform ordinary duties; or disabled—either physically or mentally—to the extent that he is unable to work at an occupation for which he is suited.

If the person applying for Medical Assistance is receiving cash assistance from the federal program of Supplemental Security Income (SSI) or agrees to apply for and is approved to receive SSI, this will be accepted as evidence that the person is either aged, blind, or disabled. If the person applying does not receive SSI and does not wish to apply for SSI, then that person's age, blindness, disability, or incapacity must be established by the Department of Public Aid—including medical examination as appropriate.

Public Institutions. Depending upon the type of care they are receiving, needy persons who reside in facilities operated by the Department of Mental Health and Developmental Disabilities may be eligible for Medical Assistance. Needy Persons age 65 and over who are residing in public tuberculosis hospitals may be eligible for Medical Assistance. Inmates of

penal or correctional institutions are ineligible. Persons about to be released from an institution may apply for Medical Assistance for services needed after release.
Persons discharged from a mental health facility solely for the purpose of receiving medical care in a general hospital, and who then return to the mental health facility may be eligible for Medical Assitance while in the general hospital.

Transfer of Property. An aged, blind or disabled person who has transferred either real or personal property for inadequate consideration within five years of the date of application for Medical Assistance is ineligible for assistance if the transfer was made for the purpose of qualifying for or increasing the need for assistance. The person is ineligible for five years from the date of the transfer, or for as long as the transferred property would meet the person's needs, whichever comes first.

Determination of Eligibility. Applicants for Medical Assistance will be expected to provide information needed to determine their eligibility. The applicant will be notified of the decision within 45 days of the date of application *(60 days if eligibility is based on disability).*
A redetermination of eligibility is made every six months or any time within the six-month period if information is received indicating a change in the recipient's circumstances which may affect the eligibility.

PAYMENT PROVISIONS

The Department will make payments for medical services provided through the Medical Assistance program to the person or institution which provides the medical service. Payments will cover only the allowable medical expenses which the eligible individual or family cannot meet from the available resources as computed in accordance with the department's standards, including such

resources as medical, surgical, or health insurance.

RIGHTS OF APPLICANTS AND RECIPIENTS

Right to Apply. Any persons who believe they may be eligible for medical services have the right to apply under the Medical Assistance program.

Choice of Vendors. Persons receiving Medical Assistance are entitled to a free choice of doctors, hospitals, or other providers of medical services which meet the requirements of and comply with the rules and regulations of the department. Recipients who are found to be overusers of medical services will be required to designate one physician who will be responsible for providing or authorizing non-emergency medical care.

Advance Notice. Persons receiving Medical Assistance will be given 10 days advance notice in writing before a local office acts to reduce, suspend, or cancel their assistance. They will also be given the opportunity for an informal conference with a local office representative to discuss the reasons for the proposed change. This is not the same as an appeal, nor does it prevent a recipient from appealing after such a conference.

Right of Appeal. An applicant or recipient may make an appeal in writing to the local public aid office or to the Illinois Department of Public Aid within 60 days. The local office will provide a form which the applicant may use in making the appeal. Legal fees are not paid by the department. If the applicant is appealing a proposed suspension, reduction, or cancellation of assistance and the appeal is filed within the 10-day advance notice period, the assistance may be continued during the hearing process.
The hearing conducted by a state hearing

officer, is without cost to the appellant and is held in the county of residence. The local office will provide for payment of unusual expenses *(transportation, child care)* that might prevent an appellant's attendance at the hearing and for necessary transportation for the appellant's witnesses and representatives.

At the hearing the appellant will have the opportunity to present the case or have it presented by legal counsel or someone acting in a representative capacity, to introduce evidence and witnesses in the appellant's behalf, and to examine before and during the hearing any material the local office plans to introduce as evidence.

Unless the appellant has requested a delay in the hearing process, the department will notify the appellant by letter of its decision on the appeal and implement the appeal decision within 90 days after the appeal is filed. For complete details, see brochure DPA 377, *The Right to Appeal and to Receive a Fair Hearing.*

CIVIL RIGHTS. The Illinois Department of Public Aid administers all programs under its jurisdiction in conformance with Title VI of the Civil Rights Act of 1964, and the United States Department of Health, Education, and Welfare regulations defining state responsibilities under that Act.

Therefore, the Department of Public Aid does not, directly or through contractual or other arrangements, on the ground of race, color, sex, national origin, or handicap, deny any individual aid, care, services, or other benefits provided under the programs; differentiate in the kind of aid, care, services, or other benefits provided, or in the manner in which they are provided, subject an individual to segregation or separate treatment in any manner related to receipt of aid, care, services, or other benefits; restrict any person from having the same advantages and privileges of all others in receiving them; treat an individual differently than others in determining eligiblity or other requirements to qualify

for aid, care, services, or other benefits; deny or offer any person an opportunity different from that offered others. Persons wishing to complain of alleged discriminatory conditions or practices by the Department of Public Aid, or other agencies, institutions, organizations, or individuals, may state their complaint in a letter or on Form DPA 185, obtained at the local public aid office. The complaint may be sent to the local office or to the Illinois Department of Public Aid, Supervisor of Inquiries, 316 South Second Street, Springfield, Illinois 62762, or to the Secretary, U.S. Department of Health, Education, and Welfare, 330 Independence Avenue, S.W., Washington, D.C. 20201.

The Department of Public Aid will investigate all complaints and take corrective action when indicated by the findings. The director of the department will review the action taken, and the complainant will be informed in writing of the disposition of the complaint. Decisions may be appealed.

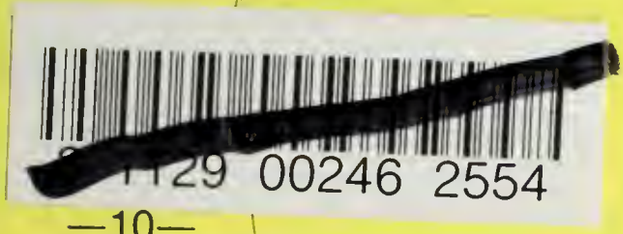
For complete details, see brochure DPA 592, *Public Aid and Civil Rights.*

Protection of Personal Information. By law the contents of department records pertaining to applicants and recipients may not be disclosed without client consent except for the purpose of administering the program.

RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS

Applicants must report accurately all income and resources including third party resources such as health insurance or Medicare and other facts which have a bearing on their eligiblity for assistance. Recipients must report immediately any change in circumstances which may affect their eligibility or the amount of the aid given.

By law, penalties are provided for falsifying or withholding information which may affect eligibility.



ESTATE CLAIMS

Claims will be made against estates to recover the amount paid for medical services in behalf of recipients of the Medical Assistance program if the recipient was 65 years of age or over at the time the Medical Assistance was received, but only after the death of the surviving spouse and only when there is no surviving child who is under 21 or who is blind or permanently and totally disabled.

The Department's Right. Sometimes the Department pays a medical bill when a third party resource such as Medicare or health insurance should have paid the bill. When this happens, the Department of Public Aid has the right, by law, to get the money from the third party resource. The Department of Public Aid does not need the client's consent to get this payment.

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